Medicaid Enterprise

Iowa Department of Human Services

HCBS Habilitation Services Provider Manual

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Iowa Department of Human Services

III. Provider-Specific Policies

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CHAPTER III. PROVIDER-SPECIFIC POLICIES

A. PROVIDERS ELIGIBLE TO PARTICIPATE

Requirements for providers eligible to enroll under the category "home- and community-based habilitation services" vary depending on the service to be provided:

Service:	**Requirement:**
Case management	Accredited as a case management provider under 441 IAC Chapter 24.
Home-based habilitation	Meet any of the following: ♦ Certified by the Department to provide supported community living (SCL) under the HCBS mental retardation waiver or brain injury waiver. ♦ Certified under 441 IAC Chapter 24 to provide supported community living. ♦ Accredited by the Commission on Accreditation of Rehabilitation Facilities as a community housing or supported living service provider. ♦ Accredited by the Council on Accreditation of Services for Families and Children (COA). ♦ Accredited by the Council for Quality and Leadership in Supports for People with Disabilities (CQL). ♦ Accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). ♦ A licensed residential care facility of 16 or fewer beds that was enrolled as a provider of rehabilitation services for adults with chronic mental illness before December 31, 2006, and has applied for accreditation through one of the above accrediting bodies.

Service:	Requirement:
Day habilitation	Meet any of the following: ♦ Accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) to provide services that qualify as day habilitation. ♦ Accredited by CARF to provide a different service, but since the last accreditation survey has begun providing services that qualify as day habilitation. When the current accreditation runs out: • The new CARF accreditation must include services that qualify as day habilitation, or • The provider must become accredited under one of the other accreditation options. ♦ Not accredited by CARF, but has applied for CARF accreditation. The accreditation process must be completed within 12 months. ♦ Accredited by the Council for Quality and Leadership in Supports for People with Disabilities (CQL). ♦ Not accredited by CQL, but has applied for CQL accreditation. The accreditation process must be completed within 12 months. ♦ Certified under 441 IAC Chapter 24 to provide day treatment or supported community living services. ♦ Certified by DHS to provide day habilitation under the HCBS mental retardation waiver. ♦ Accredited by the International Center for Clubhouse Development (ICCD). ♦ Accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). ♦ A licensed residential care facility of more than 16 beds that was enrolled as a provider of rehabilitation services for adults with chronic mental illness before December 31, 2006, and has applied for accreditation through one of the above accrediting bodies.

Service:	Requirement:
Prevocational habilitation	Meet any of the following: ♦ Accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) as an organizational employment service provider or community employment service provider. ♦ Accredited by the Council for Quality and Leadership in Supports for People with Disabilities (CQL). ♦ Accredited by the International Center for Clubhouse Development (ICCD). ♦ Certified by the department to provide Prevocational services under the HCBS mental retardation waiver or brain injury waiver.
Supported employment habilitation	Meet any of the following: ♦ Certified by the Department to provide supported employment services under the HCBS mental retardation waiver or brain injury waiver. ♦ Accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) as an organizational employment service provider or community employment service provider. ♦ Accredited by the Council on Accreditation of Services for Families and Children (COA). ♦ Accredited by the Council for Quality and Leadership in Supports for People with Disabilities (CQL). ♦ Accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). ♦ Accredited by the International Center for Clubhouse Development (ICCD).

1. Provider Enrollment

Providers eligible to participate must become enrolled with the Iowa Medicaid Enterprise (IME). To obtain enrollment forms, contact the IME Provider Enrollment Unit:

- By e-mail at: imeproviderservices@dhs.state.ia.us
- By phone 1-800-338-7909 (option 2) or 515-725-1004 from Des Moines
- Enrollment forms are also available on the IME web site at: http://www.ime.state.ia.us/Providers/Enrollment.html

Complete the enrollment application (form 470-0254), a provider agreement form (form 470-2965), and an IRS W9 form. Attach documentation showing how the accreditation or certification requirements are met. Typically this can be in the form of a copy of an accreditation certificate or a letter from the accrediting body.

Applications for providers of home-based habilitation or day habilitation that are not yet accredited but have applied for accreditation with one of the listed accrediting bodies will have 12 months to complete the accreditation process.

Any time an accreditation or certification expires, the provider must renew the accreditation or become accredited through one of the other options for the service to be provided. A provider whose certification lapses will no longer be considered a qualified provider.

Each provider shall provide the IME Provider Services Unit with the current address of the provider's primary location and any satellite offices. It is the responsibility of the provider to contact the IME Provider Services Unit and provide an update whenever:

- There is a change of address, or
- Other changes occur that affect the accuracy of the provider enrollment information.

2. Provider Requirements

As a condition of enrollment, providers of habilitation services must:

- Comply with requirements regarding organization and staff as set forth at 441 Iowa Administrative Code 77.25(2). This includes:
  - Completing child abuse, dependent adult abuse, and criminal history record checks on all employees and applicants to whom an offer of employment is made, as required by Iowa Code section 249A.29.
  - Ensuring that direct care staff are at least 16 years of age.
  - Ensuring that direct care staff do not provide services to their immediate family members.
- Comply with requirements for incident reporting as set forth at 441 Iowa Administrative Code 77.25(3).
- Comply with requirements for restraint, restrictions, and behavioral intervention as set forth at 441 Iowa Administrative Code 77.25(4). This includes:
  - Providers that do not use restraint, restrictions or behavioral intervention must have a written policy stating this.
  - Members and their legal guardians must be informed about the provider's policy and procedures.
  - Restraint, restriction, and behavioral intervention may be used only for reducing or eliminating maladaptive target behaviors that are identified in the member's restraint, restriction, or behavioral intervention program.
  - Procedures shall be designed and implemented only for the benefit of the member and shall never be used as punishment, for the convenience of the staff, or as a substitute for a non-aversive program.
- Follow standards in 441 Iowa Administrative Code 79.3(249A) for maintenance of fiscal and clinical records. These standards pertain to **all** Medicaid providers. (See Documentation.)
- Assure that any services delivered by an individual or agency, either through employment by or a contract with the enrolled provider, complies with the requirements that apply to the enrolled provider.

B. MEMBERS ELIGIBLE TO RECEIVE SERVICES

Medicaid members may receive habilitation services when they meet the following requirements:

1. Financial Eligibility

The member's countable income used in determining Medicaid eligibility must not exceed 150% of the federal poverty level. The member's DHS income maintenance worker does the poverty-level calculation at the time Medicaid eligibility is determined.

The member must be eligible for Medicaid under one of the existing coverage groups (for example: SSI-disabled, CMAP, MEPD, etc.). Each coverage group may have its own rules for determining countable income. The income maintenance worker will apply those rules when determining Medicaid eligibility.

This income limit is set in federal law. Therefore, the Department cannot change the limit or grant an exception to it.

2. Need for Service

The member must be in need of habilitation services as demonstrated by meeting the following functional criteria:

The member meets at least one of the following risk factors:

- The member has undergone or is currently undergoing psychiatric treatment more intensive than outpatient care, more than once in a lifetime (e.g., emergency services, alternative home care, partial hospitalization or inpatient hospitalization).
- The member has a history of psychiatric illness resulting in at least one episode of continuous, professional supportive care other than hospitalization.

"Psychiatric treatment" and "history of psychiatric illness" refer to conditions where diagnosis is typically made and treatment is typically ordered by a psychiatrist, but do not include primary diagnoses of mental retardation, developmental disabilities, dementias or substance abuse.

However, diagnoses of mental retardation, developmental disabilities, dementias, or substance abuse are acceptable as co-occurring disorders. Substance-abuse-induced disorders are not considered psychiatric illness.

In addition, the member has a need for assistance typically demonstrated by meeting at least two of the following criteria on a continuing or intermittent basis for at least two years:

- The member is unemployed or employed in a sheltered setting or has markedly limited skills and a poor work history.
- The member requires financial assistance for out-of-hospital maintenance and may be unable to procure this assistance without help.
- The member shows severe inability to establish or maintain a personal social support system.
- The member requires help in basic living skills such as self-care, money management, housekeeping, cooking, or medication management.
- The member exhibits inappropriate social behavior that results in demand for intervention.

The IME Medical Services Unit determines the need for service based on an assessment done by the case manager. See Assessment for more information.

3. Member Enrollment

The enrollment process is initiated by the case manager and typically follows these steps:

- The case manager makes a request for habilitation services through ISIS by going to the "Add/Cancel Program" tab in ISIS, entering the required information and clicking the "Initiate Program" button.
- ISIS then checks for Medicaid eligibility and that the member meets the income limit (see Financial Eligibility). If financial eligibility cannot be determined, ISIS sends a message to the income maintenance worker asking the worker to enter the correct poverty level for the person. If this happens, the case manager should wait a week before trying again. (See ISIS Instructions for Case Managers.)

- After Medicaid eligibility and financial eligibility are confirmed, the slot manager for IME checks for slot availability. If no slot is available, the member is placed on the waiting list (see Payment Slots).
- For adults, the county of legal settlement is determined.
- The case manager completes an assessment of the members functioning and submits it to the IME Medical Services Unit (see Assessment). IME will make the determination of whether or not the member meets the needs-based criteria (see Need for Service). In some cases, the reviewer may ask for more information.
- If the member is determined eligible, the case manager then uses the same assessment to develop the Individual Comprehensive Plan with the member's interdisciplinary team (see Comprehensive Service Plan).
- The case manager then enters the participant's service plan information into ISIS.
- The IME Medical Services Unit reviews the service plan information for authorization (see Service Authorization).
- ISIS sends a notification to the case manager and the county CPC for an adult.
- The case manager sends a *Notice of Decision* to the member and the member's service providers to notify them of the approved services.

4. Payment Slots

The number of members who may be approved for habilitation services is limited to a yearly total.

When the case manager starts the program request in ISIS, the workflow includes a milestone for the IME slot manager to check for availability of a payment slot. When a payment slot is assigned to the member, the case manager is notified in ISIS and gives the member written notice that a slot was received.

The slot remains assigned to that member as long as reasonable efforts are being made to arrange services. If the member decides not to receive services, or reasonable efforts are not being made to arrange services, the slot will revert for use by another member.

When all payment slots are assigned, IME establishes a waiting list for the program. If a member is denied a slot, the member is placed on the waiting list and a *Notice of Decision* is issued to the member to inform the member of this action. Members are placed on the waiting list based on the date and time in which the program request was entered into ISIS. The program request in ISIS will be closed.

When a payment slot becomes available, IME notifies the member's case manager who then gives the member written notice that a slot has been assigned. The case manager must then start a new program request for habilitation services in ISIS within 20 days. If a new program request is not entered within 20 days, the slot will revert to the next member on the waiting list.

5. Assessment

The case manager must complete an assessment of the member's current functioning, including the member's situation, needs, strengths, abilities, desires, and goals.

Any assessment that meets the standards in 441 Iowa Administrative Code 24.4(2) may be used. The assessments used by case management providers accredited under 441 Iowa Administrative Code Chapter 24 meet this standard, so the case manager can use the same assessment as is used for case management.

Submit the assessment to the IME Medical Services Unit by fax at: (515) 725-0931. Please be sure the assessment is clearly marked for habilitation services. Case managers may also send a social history as an attachment if it is felt that additional information is needed.

Habilitation questions for the Medical Services unit may be sent by e-mail to: habilitationservices@dhs.state.ia.us. Do **not** use this email address to submit assessments. You may also contact the Medical Services unit by phone at 1-800-383-1173, or (515) 725-1008 in the Des Moines area.

The Medical Services Unit will respond to initial assessments within two business days and will respond to annual reviews within five business days. In some cases, the reviewer may ask for additional information to be sent.

6. Comprehensive Service Plan

Services must be included in a comprehensive service plan. The comprehensive service plan must be developed by the member in collaboration with the member's interdisciplinary team, as established by the case manager, and must be updated at least annually.

The comprehensive service plan must be based on, and designed to address the needs identified in the current assessment (see Assessment) and must reflect the member's desired outcomes. The member is free to choose among enrolled providers. The selection of a provider should take into account the availability of services.

The comprehensive service plan must:

- Identify observable or measurable individual goals.
- Identify interventions and supports needed to meet those goals with incremental action steps, as appropriate.
- Identify the staff people, businesses, or organizations responsible for carrying out the interventions or supports.
- List all Medicaid and non–Medicaid services received by the member and identify:
  - The name of the provider responsible for delivering the service;
  - The funding source for the service; and
  - The number of units of service to be received by the member.
- Identify for a member receiving home–based habilitation:
  - The member's living environment at the time of enrollment;
  - The number of hours per day of on–site staff supervision needed by the member; and
  - The number of other members who will live with the member in the living unit.
- Address the member's opportunities for independence and community integration for members receiving home-based habilitation in a licensed residential care facility of 16 or fewer beds.

- Include a separate, individualized, anticipated discharge plan that is specific to each service the member receives.
- Document:
  - Any restrictions on the member's rights, including maintenance of personal funds and self–administration of medications,
  - The need for the restriction, and
  - Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.

  Any rights restrictions must be implemented in accordance with 441 Iowa Administrative Code 77.25(4).
- Include a plan for emergencies and identification of the supports available to the member in an emergency. Emergency plans shall:
  - Identify any health and safety issues applicable to the individual member based on information gathered before the team meeting, including a risk assessment.
  - Identify an emergency backup support and crisis response system to address problems or issues arising when support services are interrupted or delayed or the member's needs change.

  Providers of applicable services shall provide for emergency backup staff.

NOTE: The member's case manager prepares the comprehensive service plan. Service providers still need to complete their own service plan that provides detailed information on how they will implement the services for the member. These plans must comply with the provider's licensure and accreditation requirements as applicable.

7. Service Authorization

When the comprehensive service plan is complete, the case manager is responsible for entering service plan information in ISIS, including the services selected, the effective dates of the services, the provider selected, and the number of units of each service needed per month.

The IME Medical Services Unit must authorize the habilitation services before services may be provided. The IME Medical Services Unit will respond (authorize, deny, or request additional information) to the plan in ISIS.

A provider may bill only for dates of service on or after the effective date of the service plan. Plans may be authorized only for a maximum of 12 months.

8. ISIS Instructions for Case Managers

a. Opening the Case

Habilitation cases should be started in "pending" status until the assessment is approved. To open a pending case in ISIS:

- Go to the "Add/Cancel Program" tab.
- Enter the member's state identification number (Medicaid number) in the "State ID" field.
- Do **not** enter a beginning date in the "Program Start Date" field. Leave this field blank.
- Select habilitation services from the "Program" drop-down box.
- Click the "Initiate Program" button.
  - If the member is not Medicaid-eligible, ISIS displays a message stating, "Member is not Medicaid eligible. Refer member to apply for Medicaid." Contact the member's income maintenance worker if there are any questions about eligibility status.
  - If ISIS displays an error message stating, "The percent of poverty level is missing or is 000 or 999," this means that the calculation of federal poverty level that the income maintenance worker enters is blank or is either 000 or 999. These are generic codes that don't give the real poverty level.

    When this occurs, ISIS sends a message to the income maintenance worker asking them to enter the correct poverty level calculation in the ABC system. It may take up to a week for this to be entered and be transferred over to ISIS. When this message is received, wait a week and try again.

    Knowing the poverty level is necessary for ISIS to start the case, because the federal law that authorizes the habilitation services program limits eligibility to persons at or below 150% of the federal poverty level. (See Financial Eligibility.)

- If the member is eligible for Medicaid and meets financial eligibility, ISIS begins the Program Request and initiates a milestone for the case manager asking, "You have requested Habilitation Services. Do you want to continue?"

b. Habilitation Services Workflow

This description of workflow is specific to habilitation services. For general instructions on how to respond to ISIS milestones, please see the ***ISIS User's Guide*** (DHS Employees' Manual, Chapter 14-M).

- ♦ After the case manager confirms that the case should continue, ISIS generates a milestone to the slot manager at IME to confirm availability of a payment slot (see Payment Slots).
- ♦ After a payment slot has been assigned, ISIS generates a milestone to the case manager asking, "Is this Consumer a minor or an adult?" This milestone determines whether legal settlement determination milestones need to be completed.
  - If the member is 18 years of age or older, the case manager should choose the "Adult" response.
  - If the member is 17 years of age or younger, the case manager should choose the "Minor" response.

  For adults, legal settlement determination milestones are sent to the county central point of coordination administrator and, when necessary, to the legal settlement arbitrator for the Department.
- ♦ ISIS generates a milestone to the case manager stating, "Complete assessment and send to IME Medical Services." (See Assessment.) When the assessment has been sent, the case manager should choose the "completed" response.
- ♦ ISIS generates a milestone for the IME Medical Services reviewer to enter the assessment decision. Possible responses include:
  - **OK**. This response indicates that the assessment shows that the member meets program eligibility criteria (see Need for Service).
  - **Denied**. This response indicates that the assessment shows that the member does not meet program eligibility criteria. It generates a milestone to the case manager stating, "Services have been denied. Send NOD. Check for other services."

- **Physician Review**. This response indicates that it is not clear from the assessment information whether or not the member meets program eligibility criteria. An independent physician will review the information and make a recommendation. This option generates another "Enter Assessment Decision" milestone that can then be approved or denied.
- **Assessment Not Received**. If the assessment has not been received after seven days, this response will generate a milestone for the case manager that states, "Assessment was not received. Please resend to Medical Services." This option also generates another "Enter Assessment Decision" milestone that can then be approved or denied.

♦ When the IME Medical Services Unit has approved program eligibility, ISIS sends the case manager a milestone stating, "Complete Individual Comprehensive Plan." When the interdisciplinary team has met and developed the comprehensive service plan (see Comprehensive Service Plan), the case manager can select the "completed" response.

♦ ISIS generates a milestone for the case manager stating "Complete Service Plan Entries." The case manager should then enter the services from the comprehensive service plan in ISIS. The general procedure for entering service plans is outlined in the ***ISIS User's Guide***, with the following exceptions

- When entering habilitation services, the case manager does not enter the provider's rate. When the provider number is added for the selected service, ISIS looks up that provider's rate for the corresponding procedure code and enters it automatically.
- If a rate is displayed as $0.00, the provider does not have an established rate for that procedure code. Check with the provider to obtain the correct provider number for that service. If a provider's rate has just been approved, it may take a week for it to be loaded into ISIS.
- If a provider's rate changes after a plan is already approved, the case manager does not need to change the rate in ISIS. When a new rate is loaded in ISIS, service plans are automatically updated with the new rate.

- When a valid service plan has been entered, ISIS generates a milestone to the IME Medical Services Unit to authorize the plan. The Medical Services Unit checks the plan to see if the services are appropriate based on the assessment information previously submitted by the case manager.

The Medical Services Unit may respond by notifying the case manager that plan changes are needed. Information about these changes will be in the "notes" shown on the status page.

ISIS will generate another "Complete Service Plan Entries" milestone for the case manager to answer when the changes are complete.

- When the service plan is either authorized or denied, ISIS sends a notification milestone to the case manager. The case manager then issues the appropriate *Notice of Decision* to the member, with a copy to the providers.

c. Making a Pending Case Active

After the assessment date has been added on a pending case, you must make the case active:

- Go to the "Add/Cancel program" tab.
- Enter the member's state identification number.
- Enter the begin date (making sure it is on or after the assessment date shown in the service plan).
- Pick "Habilitation Services" from the dropdown menu.
- Click the "Initiate Program" button.

ISIS will then add the begin date to the program request that has already been started.

d. Closing a Case

To close a habilitation services case in ISIS:

- Go to the "Add/Cancel Program" tab.
- Click on the "Cancel Consumer" link.

- Enter the member's state identification number (Medicaid number) in the "State ID" field.
- Enter the date services will end in the "Program End Date" field.
- Select "Habilitation Services" from the "Program" drop-down box.
- Click the "Cancel Program" button.

e. Reopening a Closed Habilitation Services Case

Losing Medicaid eligibility for brief periods of time is a common occurrence for some members who are eligible through the MEPD or Medically Needy eligibility groups. This typically happens when Medicaid eligibility is determined at the beginning of a month and the member becomes ineligible because the MEPD premium has not yet been paid or the Medically Needy spenddown has not been met.

When Medicaid eligibility is lost, ISIS automatically closes the case. If Medicaid eligibility for the month is regained when the premium is paid or the spenddown is met, the case must be reopened in ISIS in order for habilitation services to continue. To reopen the case:

- Go to the "Add/Cancel Program" tab in ISIS and start a new program request in the same manner as when opening a new case.
- When entering the beginning date in the "Program Start Date" field, make sure the date is one day after the date the original program request ended.
- ISIS then merges the new program request with the one that was previously closed and the program will continue uninterrupted.

Example: Mr. J is receiving habilitation services in April. On May 1, he has not yet paid his MEPD premium and he does not become eligible for Medicaid for the month of May. ISIS automatically closes the habilitation services program request with an end date of April 30.

On May 15, Mr. J's premium is received and his Medicaid eligibility is granted retroactively to May 1. Mr. J's case manager enters a habilitation services program request in ISIS with a beginning date of May 1. ISIS automatically reopens the previous program request and removes the end date.

C. COVERED SERVICES

For all habilitation services, the individual member must have a need for this type of support and the need must be identified in the member's comprehensive service plan. The provider's documentation needs to state how the service is related to the member's goal as well as the member's response to the service.

Habilitation services provided under Iowa Medicaid to members include the following:

1. Case Management

Case management assists members in gaining access to needed home- and community-based habilitation services, as well as medical, social, educational, and other services, regardless of the funding source for the services to which access is gained. This includes the following activities:

- Explaining the member's right to freedom of choice.
- Assuring that all unmet needs of the member are identified in the comprehensive service plan.
- Explaining to the member what abuse is and how to report abuse.
- Explaining to the member how to make a complaint about the member's services or providers.
- Monitoring the comprehensive service plan, with review occurring regularly.
- Meeting with the member face-to-face at least quarterly.
- Assessing and revising the comprehensive service plan at least annually to determine achievement, continued need, or change in goals or intervention methods. The review shall include the member and shall involve the interdisciplinary team.
- Notifying the member of any changes in the service plan by sending the member a notice of decision. When the change is an adverse action such as a reduction in services, the notice shall be made ten days before the change and shall include appeal rights.

Case management may only be provided as a service through the Habilitation program to a member who is not authorized to receive Medicaid targeted case management under 441 Iowa Administrative Code Chapter 90.

2. Home-Based Habilitation

Home-based habilitation consists of individualized services and supports that assist with the acquisition, retention, or improvement in skills related to living in the community.

These services are provided in the member's home or community and assist the member to reside in the most integrated setting appropriate to the member's needs. Services are intended to provide for the daily living needs of the member and can be provided at any time of day or night that is necessary to meet the member's needs. This includes the following supports:

- Adaptive skill development
- Assistance with activities of daily living
- Community inclusion
- Transportation (except to and from a day program)
- Adult educational supports
- Social and leisure skill development
- Personal care
- Protective oversight and supervision

Example: Client J needs help with cooking and laundry skills. Provider staff come to his apartment for an hour in the daytime and an hour in the evening to assist him in gaining cooking skills. Staff also work with Client J on laundry skills for two hours every Saturday afternoon. These activities would be considered adaptive skill development and are reimbursable.

Example: Client L's symptom of paranoia keeps her from going grocery shopping because she feels like other people in the store are spying on her. Provider staff take her grocery shopping for two hours every Wednesday afternoon. Staff assist her in using coping skills and "reality checks" to allay her feelings of paranoia. This activity includes adaptive skill development, community inclusion, and transportation and is reimbursable.

Example: Despite dealing with bipolar disorder for many years, Client N is returning to college at his local community college. Provider staff assist him in learning appropriate behavior for that setting, and on developing time management skills. They also assist him in completing the necessary paperwork and scheduling requirements. These activities would be considered adult educational supports and are reimbursable.

Transportation is acceptable if it supports the acquisition, retention, or improvement of another skill, such as grocery shopping, getting medical care, etc.

Personal care and protective oversight and supervision may be a component part of home-based habilitation services but may not comprise the entirety of the service.

Home-based habilitation cannot be provided to members who reside in a residential facility of more than 16 beds.

Even when home-based habilitation is provided using a daily rate, it does not include room and board or maintenance costs.

Activities associated with vocational services, day care, medical services, or case management cannot be included in home-based habilitation.

> **Example:** Even when done in a member's home, providing assistance in completing a job application would be a vocational service, not a home-based habilitation service, and would not be allowed.

> **Example:** Assisting a member in making a medical appointment or calling in a refill for a prescription would be providing assistance with accessing medical services, but are **not** medical services themselves, and would be allowed.

3. Day Habilitation

Day habilitation is assistance with acquisition, retention, or improvement in self-help, socialization, and adaptive skills. Day habilitation activities and environments are designed to foster the acquisition of skills, appropriate behavior, greater independence, and personal choice. Services focus on enabling the member to attain or maintain the member's maximum functional level. Services must enhance or support the member's:

- Intellectual functioning.
- Physical and emotional health and development.
- Language and communication development.
- Cognitive functioning.
- Socialization and community integration.
- Functional skill development.
- Behavior management.
- Responsibility and self-direction.

- Daily living activities.
- Self-advocacy skills.
- Mobility.

Example: Client M has difficulty in recognizing appropriate physical boundaries and often stands too close to others, violating their sense of personal space. Provider staff work with Client M to help her learn appropriate boundaries, and redirect her when this behavior occurs. This would be considered behavior management, and is a reimbursable service.

Example: Client C tends to isolate himself and has very little interaction with other people. Provider staff at his day habilitation program help Client C with learning social skills and take him on outings in the community where he can practice using these skills with staff assistance. This would be considered socialization and community integration, and is a reimbursable service.

Example: A day habilitation provider takes a group of five members on a community outing to a local festival. Two members have goals in their comprehensive service plans that involve increasing socialization and community inclusion; the other three do not have an identified need for this.

This activity would be considered socialization and community integration and would be reimbursable for the two members with a need for this support identified in their comprehensive service plan, but would not be reimbursable for the other three members.

Day habilitation cannot be provided in the member's residence. If the member lives in a residential facility of more than 16 persons, day habilitation can be provided in an area of the facility that is apart from the member's sleeping accommodations, such as a common room where residents normally congregate.

4. Prevocational Habilitation

Prevocational habilitation services are designed to prepare a member for paid or unpaid employment. This means teaching concepts such as compliance, attendance, task completion, problem solving, and safety. This does not include training to do any specific job or task, but instead is aimed at a generalized result that can be used in an employment setting.

Prevocational services can be provided in a variety of settings from the member's home or a community setting to a sheltered workshop, depending on the needs of the member.

Example: Due to his chronic schizophrenia, Client K has never been employed. He has difficulty getting up on time and dressing appropriately for a work setting. Provider staff come to his home for an hour each morning on Monday through Friday to help him in acquiring these skills. He then attends a sheltered workshop where he assembles widgets for four hours per day.

The hour of staff assistance each morning is an acceptable prevocational service and is reimbursable. Assembling widgets at the workshop is vocational, not prevocational, and is not reimbursable.

Example: Client T attends a sheltered workshop where she works assembling widgets four hours per day. For two of those hours, provider staff work with her on maintaining concentration and task completion. For the other two hours, she works under staff supervision, but is not involved in any prevocational skills training activity.

The two hours that staff assist her are acceptable as a prevocational service and are reimbursable. The remaining time is not prevocational and not reimbursable.

The member cannot be paid from Medicaid funds for work performed while receiving prevocational services. If a provider chooses to compensate a member for such work, the provider must use non-Medicaid funding and must be able to document the funding source.

Prevocational services are designed to be provided for a limited time in order to prepare a member for employment.

If a member has been receiving prevocational services for more than one year and is not ready for regular employment, the interdisciplinary team should re-evaluate the necessity of prevocational services and explore other service options to meet the member's vocational needs, if necessary.

5. Supported Employment Habilitation

Supported employment is designed to assist members in obtaining and maintaining competitive paid employment. The service consists of intensive, ongoing supports that enable members to perform in a regular work setting.

Services are provided to members who need support because of their disabilities and who are unlikely to obtain competitive employment at or above the minimum wage without the provision of supports.

Supported employment has two main components:

- Activities to obtain a job, and
- Supports to maintain employment.

Activities to obtain a job include the following service components provided to or on behalf of the member:

- **Job development** services are directed toward obtaining competitive employment. The activities provided to the member may include:
  - Job procurement training, including grooming and hygiene, application, resume development, interviewing skills, follow-up letters, and job search activities.
  - Job retention training, including promptness, coworker relations, transportation skills, disability-related supports, job benefits, and an understanding of employee rights and self-advocacy; and customized job development specific to the consumer.

  A unit of service is a job placement that the member holds for 30 consecutive calendar days or more. A member may receive two units of job development services during a 12-month period.

Payment for job development may occur when the service has been authorized in the member's service plan. Iowa Vocational Rehabilitation Services will continue to provide a letter, upon request, confirming that the Medicaid member is not eligible for funding through that agency.

- **Employer development** services are focused on supporting employers in hiring and retaining members in their workforce and to communicate expectations of the business with the interdisciplinary team. Employer development services may be provided only to members who are reasonably expected to work for no more than 10 hours per week.

  The services provided may include:

  - Developing relationships with employers and providing leads for individual members when appropriate.
  - Job analysis for a specific job.
  - Development of a customized training plan that identifies job-specific skill requirements, employer expectations, teaching strategies, timeframes, and responsibilities.
  - Identifying and arranging reasonable accommodations with the employer.
  - Providing disability awareness and training to the employer when it is deemed necessary.
  - Providing technical assistance to the employer regarding the training progress as identified on the member's customized training plan.

  Most members will receive this service through Iowa Vocational Rehabilitation Services. Iowa Vocational Rehabilitation Services will continue to provide a letter, upon request, confirming that the Medicaid member is not eligible for funding through that agency.

  A unit of service is one job placement that the member holds for 30 consecutive calendar days or more. Payment for this service may be made only after the member holds the job for 30 days. A member may receive two units of employer development during a 12-month period.

- **Enhanced job search** activities are associated with obtaining initial employment after job development services have been provided for a minimum of 30 days; or with assisting the member in changing jobs due to lay-off, termination, or personal choice.

  The interdisciplinary team must review and update Iowa Vocational Rehabilitation Services form SES/RA-1, *Supported Employment Readiness Analysis*, to determine if this service remains appropriate for the member's employment goals. Click here to see a sample of this form.

  The services provided may include:

  - Job opening identification with the member.
  - Assistance with applying for a job, including completion of applications or interviews.
  - Work site assessment and job accommodation evaluation.

  A unit of service is an hour. A maximum of 26 units may be provided in a 12-month period. Iowa Vocational Rehabilitation Services will continue to provide a letter, upon request, confirming that the Medicaid Member is not eligible for their funding.

Supports to maintain employment includes the following services provided to or on behalf of the member:

- Individual work-related behavioral management.
- Job coaching.
- On-the-job or work-related crisis intervention.
- Assistance in the use of skills related to sustaining competitive paid employment, including assistance with communication skills, problem solving, and safety.
- Assistance with time management.
- Assistance with appropriate grooming.
- Employment-related supportive contacts.
- On-site vocational assessment after employment.
- Employer consultation.

Example: Due to his bi-polar disorder, Client B has never been employed, but he would like to work. His provider finds that Client B has an interest and aptitude for working with animals.

The provider contacts local pet stores to explain Client B's situation and arranges for a job interview for Client B. These activities would be considered job procurement training and are reimbursable as "job development services"

The employer hires Client B to help take care of the animals. Provider staff work with Client B to assist him in learning his job duties. During the first two weeks, the provider works with Client B at the job site for an hour per day. For the next two weeks, staff assist him every other day.

Staff also makes periodic contact with the employer to check on Client B's performance and identify any trouble areas.

These activities are considered job coaching and employer consultation and would be reimbursable as "supports to maintain employment."

One day, Client B becomes agitated while at work and yells at another employee. Provider staff respond by coming to the job site and assisting Client B in regaining his composure. The staff finds that Client B was confused about some of his duties and became upset when his co-worker pointed out some things Client B had not done.

Provider staff then assists Client B in communicating about the problem with the employer and co-worker and in clarifying his duties.

These activities are considered work-related crisis intervention and assistance with communication skills and are reimbursable as "supports to maintain employment."

Supported employment can be provided in a variety of community-based settings where people without disabilities work. The majority of co-workers at any employment site with more than two employees must be persons without disabilities.

In the performance of job duties, the member must have daily contact with other employees or members of the public who do not have disabilities, unless the absence of such contact is typical of the job for persons without disabilities.

When supports for maintaining employment are provided to members in a teamwork or "enclave" setting, the team must not include more than eight people with disabilities.

Community transportation options (such as driving oneself, carpools, public transportation, being transported by co-workers, families, volunteers, etc.) shall be attempted before the service provider provides transportation.

6. Excluded Services

Habilitation services do not include any of the following:

- Respite services.
- Room and board.
- Family support services.
- Inpatient hospital services.
- Services that are solely educational in nature.
- Services that are not in the member's comprehensive service plan.
- Services provided before the approval of a member's plan by the Iowa Medicaid Enterprise.
- Services to persons under 65 years of age who reside in institutions for mental diseases.
- Services directed at a parent or family member to meet the protective, supportive, or preventive needs of a child. Services that are otherwise covered by the Iowa Medicaid program or that are an integral and inseparable part of another Medicaid-reimbursable service, including but not limited to:
  - Institutional services, such as in a nursing facility or ICF/MR.
  - Services under a behavioral health managed care program, such as Assertive Community Treatment (ACT).

7. Duplication

Members may be enrolled for HCBS habilitation services while also enrolled in an HCBS waiver program under the following conditions:

- The member must meet all eligibility requirements for both programs.

- Services may not be duplicated between the two programs. When a needed service is available under both programs, it should be accessed through habilitation services rather than the waiver.
- Only one case manager is permitted per member. When case management is to be provided as an HCBS service, such as with the elderly waiver, the habilitation case manager must oversee both programs.

8. Medical Necessity

To be payable by Medicaid as a habilitation service, a service must:

- Be reasonable and necessary.
- Be based on the member's needs as identified in the member's comprehensive service plan.
- Be delivered in the least restrictive environment appropriate to the needs of the member.
- Be provided at the most appropriate level for the individual member.
- Include the applicable and necessary instruction, supervision, assistance, and support required by the member to achieve the member's life goals.
- Be consistent with professionally accepted guidelines and standards of practice for the service being provided.

9. Documentation

Providers must meet the documentation requirements set forth in 441 Iowa Administrative Code 79.3(249A).

The medical record shall indicate the member's progress in response to the services rendered, including any changes in treatment, alteration of the plan of care, or revision of the diagnosis.

Providers must maintain the medical records for five years from the date of service as evidence that the services provided were:

- Medically necessary;
- Consistent with the diagnosis of the member's condition; and
- Consistent with professionally recognized standards of care.

Each page of the medical record shall contain the member's first and last name. As part of the medical record, the member's medical assistance identification number and date of birth must be identified and associated with the member's first and last name.

The provider's file for each Medicaid member **must** include progress notes for **each** date of service that detail specific services rendered related to the covered habilitation service for which a claim is submitted to the Iowa Medicaid program.

The following items must be included in **each** progress note entry, for **each** Medicaid member, and for **each** date of service:

- The date and amount of time services were delivered, including the beginning and ending time of service delivery.
- The first and last name and title of provider staff actually rendering service, as well as that person's signature.
- The place of service (i.e., location where service was actually rendered).
- A description of the specific components of the Medicaid-payable habilitation service being provided (using service description terminology from the covered services section of this manual).
- The nature, extent, and number units of the habilitation service that was rendered. The progress note **must** describe what specifically was done, and include the progress and barriers to achieving the goals and objectives as stated in the member's comprehensive service plan.
- The name, dosage, and route of administration of any medication administered, when it is a part of the service.

At the conclusion of services, the member's record shall include a discharge summary that identifies:

- The reason for discharge,
- The date of discharge,
- The recommended action or referrals upon discharge, and
- The treatment progress and outcomes.

D. PROCEDURE CODES AND NOMENCLATURE

These procedure codes may be used in submitting bills for habilitation services:

Code	Description
W1330	Case management
W1204	Day habilitation (daily)
W1205	Day habilitation (half-day)
W1206	Day habilitation (hourly)
W1207	Home-based habilitation (hourly)
W1208	Home-based habilitation (daily)
W1425	Prevocational habilitation (daily)
W1426	Prevocational habilitation (half-day)
W4425	Prevocational habilitation (hourly)
W5019	Supported employment, job development (per job)
W5020	Supported employment, employer development (per job)
W5021	Supported employment, enhanced job search (hourly)
W1431	Supported employment, supports to maintain employment, job coaching (hourly)
W1432	Supported employment, supports to maintain employment, personal care (hourly)
W1433	Supported employment, supports to maintain employment, enclave (hourly)

For home-based habilitation, a daily rate may be established when a member receives direct supervision for 14 or more hours per day averaged over a calendar month.

For day habilitation and prevocational habilitation, a half-day is 1 to 4 hours and a full day is 4 to 8 hours.

For supported employment, a unit of service is hourly, except for job development and employer development, which are paid per job placement up to two times per 12-month period.

Submit bills for whole units of service only. For all hourly services, round the number of units by adding the total number of units provided during the month and dividing by 60 minutes to obtain the total number of hours.

E. BASIS OF PAYMENT FOR SERVICES

1. Submission of Cost Reports

Habilitation services providers shall submit their cost reports using form 470-4425, *Financial and Statistical Report for Habilitation Services*.

Providers also shall submit the cross walked working trial balance that was used to complete the cost report.

Providers may obtain form 470-4425 by contacting IME Provider Cost Audit and Rate Setting Unit. The cost report is available either electronically in Microsoft Excel software or as hard copy. Electronic versions of the cost report can be found at the following IME links:

- Consolidated (parent): http://www.ime.state.ia.us/docs/HabilitationWaiverParentCostReport.xls
- Non-consolidated: http://www.ime.state.ia.us/docs/HabilitationWaiverCostReport.xls

New providers not having historical costs may complete the report using projected costs. Only the certification page, Schedule D, and Schedule F of form 470-4425 are required.

You may submit your cost reports electronically via e-mail to: costaudit@dhs.state.ia.us. Sending the cost report electronically allows the IME Provider Audits and Rate Setting Unit to begin processing the desk review of the cost report sooner.

Regardless of whether you are submitting an electronic or printed version of the cost report, you must also submit a printed, signed copy of the certification page. Send the signed certification page of the cost report to:

Iowa Medicaid Enterprise
Attention: Provider Cost Audits and Rate Setting Unit
P.O. Box 36450
Des Moines, Iowa 50315

Submit actual, final costs report no later than the last day of the third month following the close of the fiscal period.

Provide supporting documentation for the allocation method used in determining indirect costs and in apportioning direct costs. In general, ensure that supporting documentation is maintained for all costs reported and numbers of staff devoted to habilitation services. This documentation must be kept available in a format that can be easily audited at any time.

2. Instructions for Completing the Cost Report

Make sure that all applicable schedules are fully completed. Enter identifying information at the top of each schedule. All information called for in the schedules must be furnished unless it does not apply to your agency. Round monetary amounts to the nearest whole dollar.

In the Excel version of the cost report, many cells are locked because they contain links to other worksheets or contain formulas. To move from one input cell to another, use the tab key.

Adjustments to convert to an accrual basis of accounting are required if your records are maintained on another accounting basis. The intent of these adjustments is to obtain information concerning costs of providing services on a basis that is fair and comparable among providers of the service.

Costs reported for habilitation services shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs for habilitation services.

a. Cost Principles

Current OMB Circular A-87 guidelines require capitalization of fixed assets when they have a useful life of more than one year and an acquisition cost which equals the lesser of:

- $5,000.00, or
- The capitalization level established by the county or other entity for financial reporting purposes.

For purposes of Medicaid-payable services, OMB guidelines for depreciation and amortization reimbursement apply. It is the Iowa Department of Human Services' policy to allow a three-year write-off of computer equipment and software programs.

OMB Circular A-87 reflects financing costs (including interest) paid or incurred on or after September 1, 1995, associated with building acquisition, construction, fabrication, reconstruction, or remodeling completed on or after October 1, 1980, as allowable. Financing costs (including interest) paid or incurred on and after September 1, 1995, for operating purposes are also allowable.

Allowable costs will be limited to those costs that are considered reasonable, necessary, and related to the service provided to the recipient.

"Reasonable cost" for purposes of Medicaid-payable services is defined as that amount of cost or expense that would ordinarily be incurred by similar providers in similar markets. It is that level of cost which a prudent and cost conscious buyer of goods and services is ordinarily willing to incur in providing these kinds of services.

b. Multiple Locations or Multiple Rates

The instructions detailed below apply to each single cost report submitted by agencies under a given provider number. Providers are encouraged to use only one provider number when possible.

Agencies that provide programs and services at more than one location are allowed to obtain additional provider numbers and submit a cost report for each separate provider number if there is substantial difference in costs between locations.

Agencies that operate under more than one Medicaid provider number must also prepare and submit a special cost report consolidating the data from all cost reports prepared under each individual habilitation services provider number.

The inclusion of all agency costs in this special "parent" cost report is required so that:

- The allocation of costs to all services and programs of the agency may be observed together as one calculation overall; and
- Consistency in these cost allocations can be reviewed from one fiscal period to the next.

c. Identification Page

Fill in the top five lines. For "Report type," enter either "Projected" or "Actual." Enter the FYE (fiscal year end) as MM/DD/YY (e.g., 06/30/01).

The purpose of the certification page is to report agency statistical information and record the signature of the authorized officer of the agency. You must complete every item on this page.

Agency Name and **Address:** Enter the official name and address of your agency. Generally, this is the name and address that appears on the license or official agency letterhead.

IRS ID No.: Enter the number assigned the facility for federal tax purposes (federal withholding, etc.).

Provider No.: Enter either the Medicaid provider number assigned to your agency at certification, or your National Provider Identifier (NPI number) and Taxonomy code. (NOTE: If you have multiple Medicaid provider numbers, you must prepare a separate cost report for each number and also a "parent" cost report for the entire agency.)

Period of Report: Enter the dates for which the current information is being provided.

Date of Fiscal Year End: Enter the ending date for your fiscal year.

Names and Telephone Numbers: Self-explanatory.

Audit: Indicate if your agency had a certified public accounting firm perform an audit of its financial statements. Forward a copy of the latest independent audit to the Department when available.

Type of Entity and Control: Indicate the ownership and control under which your agency is conducted.

Accounting Basis: Indicate the basis on which you keep your books.

- Accrual: Record revenue when earned and expenses when incurred.
- Cash: Record revenue when received and expenses when paid.
- Modified Cash: Combination of cash and accrual methods.

The accrual basis is the required method for the purpose of establishing rates and determining settlements based on actual cost. If you do not use the accrual basis of accounting, you **must** adjust reported amounts to the accrual basis. Keep the accounting work papers used in adjusting your records from cash to accrual.

Statistical Data: Enter the appropriate number of units for the reporting period for each procedure code. "Billable time" means direct face-to-face contact with the member. Units should include all units of service provided, regardless of whether or not payment has been received.

For unit rounding guidelines, refer to PROCEDURE CODES AND NOMENCLATURE.

Signatures: Signatures are required as follows:

- **Item D:** "The Officer or Administrator of Facility" should be the person at the agency who is ultimately responsible for the content of the report.
- **Item E:** "Statement of Preparer (If Other than Agency)" should be signed by the person who actually prepared the report.
- **Item F:** "Statement of Project Manager" refers to a DHS employee, if applicable.

d. Schedule A

The purpose of Schedule A, Revenue Report, is to report total agency income and the income allocated to the specific services and programs. Report all revenues, including those from other programs.

Report the total revenues or gross income in the column headed "Total Revenue." Revenue categories are provided on the schedule for the most common sources. If additional categories are necessary, submit accompanying schedules.

Revenues are generally broken down into three classifications for purposes of completing this report:

- **Fees for services** represent income earned as a result of performing services to or for members. Third parties might pay the fees on behalf of members for which services were performed.
- **Other income** includes program revenues from:
  - The sale of products,
  - Food reimbursements from the Department of Education, and
  - Investment income that is not from restricted or appropriated contributions and is held separate and not commingled with other funds.

  Additional other income items may be applicable. If so, identify them accordingly or support them by an accompanying schedule.
- **Contributions** include all United Way funding, other donations, and government grants that are not designated as fees for services. When reporting income from contributions, you must also submit a schedule showing the contribution and its anticipated designation. Report the contributions as "restricted" or "appropriated" as follows:
  - Restricted or appropriated: Include funds that are either appropriated by the provider through formal board action or restricted by the donor. This includes interest from the contribution, when this interest is also restricted or appropriated and is held separate and not commingled with other funds.
  - Not restricted or appropriated: Include donations that are not appropriated or designated by the provider through board action or restriction by the donor.
  - Government grants: Government grants should be explained on an accompanying schedule that sets forth the source of funding, the purpose and the period of the grant, and the program to which the grant pertains.

NOTE: Income generated from agency activities not directly related to the provision of member service and from restricted or appropriated contributions should be reflected on Schedule D as a reduction of related expense (i.e., interest income should be offset to the extent of related interest expense).

Report this reduction against expense either in Column 2 of Schedule D or on the last page of Schedule D. Report each deduction only once.

e. Schedule B

The purpose of Schedule B, Staff Numbers and Wages, is to reflect:

- The count of full-time and part-time staff for the entire agency or location.
- Full-time equivalent numbers of all staff, staff positions, and titles.
- Salaries or wages by position for all staff.

Job Classification and Title: Enter the job titles in the space provided on the left following the position classifications. All personnel must be separated into the following job classifications:

- 2110 Administrative
- 2120 Professional
- 2130 Direct client care
- 2150 Clerical
- 2190 Other staff

Number of Staff: Enter the number of persons working full time or part time, and the total full-time equivalents (FTEs) for each job title.

Examples for a cost report period ended June 30:

1. A full-time employee (1.0 FTE) starts in January. The worked FTE to be reported on Schedule B for the fiscal year would be:

   (1.0 FTE / 12 months * 6 months) = **0.50 FTE**

2. A full-time employee (1.0 FTE) starts in November. The worked FTE to be reported on Schedule B for the fiscal year would be:

   (1.0 FTE / 12 months * 8 months) = **0.67 FTE**

3. A part-time employee starts in January. The employee works 24 hours per week (24 hours / 40 hours = 0.6 FTE). The worked FTE to be reported on Schedule B for the fiscal year would be:

   (0.60 FTE / 12 months * 6 months) = **0.30 FTE**

4. A part-time employee starts in March. The employee works 16 hours per week (16 hours / 40 hours = 0.4 FTE). The worked FTE to be reported on Schedule B for the fiscal year would be:

   (0.40 FTE / 12 months * 4 months) = **0.13 FTE**

5. A part-time employee working 24 hours per week (24 hrs / 40 hrs = 0.6 FTE) becomes a full-time employee (1.0 FTE) starting in November. The worked FTE to be reported on Schedule B for the fiscal year would be:

   (0.60 FTE / 12 months * 4 months) = 0.20 FTE plus
   (1.0 FTE / 12 months * 8 months) = 0.67 FTE = **0.87 FTE**

Gross Wages: Enter the gross salaries and wages for all full-time and part-time staff for each job title for the entire agency or location. Make sure the salaries and wages here correspond with the respective salary lines on Schedule D, Expense Report (lines 2110 - 2190). (In the electronic version of these forms, this link is automatic.)

After the columns are completed, enter subtotals and total as indicated.

Providers are required to maintain supporting documentation identifying the number and type of staff and FTEs devoted to habilitation services and to each individual habilitation service. You should maintain a separate staffing record for each habilitation service in a Schedule B format.

f. Schedule C

The purpose of Schedule C, Property and Equipment Depreciation and Related Party Property Cost, is to report information related to tangible and intangible depreciable assets, leaseholds, and start-up costs.

Schedule C includes the original acquisition costs, capital improvements, and depreciation on buildings and equipment owned by the provider. If property is being leased from a related party, information regarding the lessor's costs must be submitted on Schedule C.

The totals reported on Schedule C are reported on Schedule D, account 4400. Ongoing expenses, such as maintenance and repairs for this property, are entered on Schedule D under subheadings for either 2800 (occupancy) or 4300 (repair expenses).

Agencies must make sure the depreciation expense on this schedule corresponds with the Depreciation lines on Schedule D, Expense Report (lines 4410 - 4480). In the electronic version of these forms, this link is automatic.

NOTE: Any property expenses related to providing room and board are not reimbursable under habilitation services and should be excluded.

In lieu of preparing Schedule C, you may submit a copy of your annual depreciation report reflecting the details of each fixed asset, including annual depreciation. The report totals must carry over to Schedule D.

Use the guidelines from OMB Circular A-87 on depreciation and amortization reimbursement. Calculate depreciation expense on a straight-line basis over the estimated useful life of the assets. Follow The Estimated Useful Lives of Depreciable Hospital Assets, published by the American Hospital Association, for depreciation.

- If a depreciable asset has at the time of its acquisition an estimated useful life of at least two years and a historical cost of at least $5,000, its cost must be capitalized and written off ratably over the estimated useful life of the asset using one of the approved methods of depreciation.
- If a depreciable asset has a historical cost of less than $5,000, or if the asset has a useful life of less than two years, its cost is allowable in the year it is acquired.

The straight-line depreciation method is required for habilitation services rate setting and cost settlement purposes. Any difference between the amount of depreciation recorded in your general ledger and the straight-line method should be reflected on Schedule D, Excluded Costs column, as an adjustment of expense.

You must establish and apply a depreciation policy consistently from one fiscal period to the next to determine how much depreciation to claim in the first and last years if a purchase is made mid-year. Available methods include:

- Taking a full year in the year of acquisition and none in the year of disposal,
- Taking no depreciation in the year of acquisition and a full year in the year of disposal, or
- Calculating the exact months' worth in both these years.

Agencies are asked to itemize fixed assets on this schedule where different depreciable lives are used. Smaller fixed assets may be grouped together for reporting purposes as long as each group of assets is being depreciated over the same useful life.

Start-Up Cost

In April 1998, the American Institute of Certified Public Accountants (AICPA) issued Statement of Position (SOP) 98-5, Reporting on the Costs of Start-Up Activities. SOP 98-5 stated that start-up costs are those incurred during the course of undertaking one-time activities related to:

- Opening a new facility,
- Introducing a new product or service,
- Conducting business in a new territory,
- Conducting business with a new class of customer or beneficiary,
- Initiating a new process in an existing facility,
- Commencing some new operation, or
- Organizing a new entity (frequently referred to as organization costs).

Start-up cost within the scope of SOP 98-5 are required to be expensed as they are incurred, rather than capitalized, which has been the usual practice.

Cost defined to be outside of the scope of the SOP include:

- Costs of acquiring or constructing long-lived assets and preparing them for intended uses.
- Costs of acquiring or producing inventory.
- Costs of acquiring intangible assets.
- Costs related to internally developed assets.
- Costs that are within the scope of FASB Statement No. 2, Accounting for Research and Development Costs, and FASB Statement No. 71, Accounting for the Effects of Certain Types of Regulation.
- Cost of fund-raising incurred by not-for-profit organizations.
- Costs of raising capital.
- Costs of advertising.
- Costs incurred in connection with existing contracts as stated in paragraph 75d of SOP No. 81-1, Accounting for Performance of Construction-Type and Certain Production-Type Contracts.

The cost outside of the scope of SOP 98-5 should be accounted for in accordance with other existing authoritative accounting recommendations.

Original Cost: Record the property and equipment at its original cost. Each asset or group of like assets should be reflected individually.

When items are purchased as an integrated system, all items must be considered as a single asset when applying the capitalization threshold. Items that have a stand-alone functional capability may be considered on an item-by-item basis. For example:

- An integrated system of office furniture (interlocking panels, desktops that are supported by locking into panels) must be considered as a single asset when applying the threshold.
- Stand-alone office furniture (e.g., chairs, free standing desks) is considered on an item-by-item basis.

Depreciation Recorded Prior Years: Obtain this information by adding the depreciation accumulated from previous years less any disposals.

Method: Enter the method used in calculating depreciation.

Annual % Rate: Enter the annual percentage rate used in calculating the depreciation. NOTE: The annual percentage rate and the recorded depreciation expense should correlate.

> For example: If you plan to depreciate a $5,000 piece of equipment equally over 5 years at $1,000 per year, the percentage in the Annual % column should be 20%.

Recorded Depreciation Expense: Enter the total amount of straight-line depreciation. If the agency uses a method other than straight-line, any difference between the amount of depreciation recorded your general ledger and the straight-line method should be reflected on Schedule D, Excluded Costs column, as an adjustment of expense.

Related Party Property Costs: A "related party" is defined as an organization related through control, form ownership, capital investment, directorship, or other means. Organizations are required to disclose their financial and statistical records to determine whether a related party relationship exists and to document the validity of costs.

If property is leased from a related party, the rent expense must be classified as a nonreimbursable cost on Schedule D, with the actual cost of the property substituted. A schedule of lessor's cost is included on Schedule C for purposes of identifying the actual cost incurred by the related party landlord.

g. Schedule D

The purpose of Schedule D, Expense Report, is to report total agency expenses and allocate those expenses to the various services provided by an agency. The allocation of costs per service includes all costs for your agency and should be consistent with the costs included on your general ledger.

Reflect on this schedule the total costs of operation of **all** programs and services you provide , as opposed to just reflecting the costs of habilitation services.

In addition to the columns for habilitation services, Schedule D includes:

- A column for the direct costs of programs and services rendered other than habilitation.
- A column available for reflecting all indirect costs that cannot be directly attributed to any one program or service.

The inclusion of all agency costs on this schedule is required so that:

- The allocation or apportionment of costs to all services and programs of the agency may be observed together as one overall calculation.
- Consistency in these cost allocations can be reviewed from one fiscal period to the next.

(1) Column Descriptions

Gross Total (Column 1): This column shows the total operating costs of the agency. The expenses reported in this column should equal the total expenses included in the agency's audited financial statements. Any difference between the amounts shown in this column and the audited financial statements, general ledger, or working trial balance must be disclosed in a supplemental schedule.

Revenue Adjustments (Column 2): Use column 2 to show any adjustment to remove costs related to revenue from allowable costs.

Excluded Costs (Column 3): Use column 3 to show any adjustments or reclassifications related to costs that are not reimbursed by the Medicaid program (i.e., fund raising costs, bad debts, promotional advertising/marketing, fines or penalties, etc.) in accordance with OMB A-87.

An example of nonreimbursable costs is the difference between book depreciation expense and depreciation under the straight-line method.

Adjusted Costs (Column 4): Column 4 shows costs that are allowable and allocable to habilitation services programs, other programs, group care programs, and indirect administrative costs. Indicate the balance of the expenses after deducting the items reflected in Columns 2 and 3 (adjustments to revenue and expense).

Direct Service Cost Beginning with column 5, report costs directly associated with:

- Day habilitation – daily (W1204)
- Day habilitation – half-day (W1205)
- Day habilitation – hourly (W1206)
- Home-based habilitation – hourly (W1207)
- Home-based habilitation – daily (W1208)
- Prevocational habilitation – hourly (W4425)
- Prevocational habilitation – half-day (W1426)
- Prevocational habilitation – daily (W1425)
- Supported employment: obtain a job (W1430)
- Supported employment: job coaching – hourly (W1431)
- Supported employment: personal care – hourly (W1432)
- Supported employment: enclave – hourly (W1433)
- Supported employment: enhanced job search – hourly (W5021)

Use the next column to report the consolidated direct costs of all other programs and services rendered at the location or site in question. This column should include the direct costs of supported employment job development (W5019) and employer development (W5020). These services are paid based on a fee schedule and are not cost-settled.

You must maintain supporting working papers to support the costs reflected in this column. These working papers must be organized by individual location or site, in detail by program or service, and in an easily audited format. The Iowa Medicaid Enterprise may conduct periodic audits of this information.

Report direct costs by service. In this accounting procedure, "direct" service expense includes all direct personnel involved in a service. It includes the supervisor of that service or the appropriate prorated share of the supervisor's time.

Expenses other than wages and fringe benefits can be charged as direct service expense if they are identifiable to a specific service.

Examples of non-billable direct costs include:

- Mileage costs for travel necessary in the provision of service
- Time spent documenting services provided
- Time spent in staff meetings related to a particular member or habilitation service

Indirect Service Costs The column after the last direct service column should include those service and administrative expenses that cannot be directly related to any specific service or program. These costs will be allocated across all programs and services after all other costs have been apportioned. Do not include indirect costs in the direct cost columns.

Indirect costs after adjustments for revenue and expense should be shown. Some examples of indirect administrative cost are:

- Staff development and training
- Receptionist position
- Office supplies
- Telephone
- Rent for administrative offices
- Property or liability insurance

To the extent possible, itemize your indirect costs by line item or account. All line items may be used as appropriate to report indirect costs.

All indirect costs should be shown by line item in this column and then allocated in total to the various programs. Each agency is responsible for developing an acceptable method of distributing the indirect service costs to the various programs and supporting its rationale.

The standard method for allocating indirect costs to different programs and services is based on the total of accumulated direct costs for each program or service before the indirect cost allocation.

If you believe that you can justify an alternate method of allocating indirect costs (e.g., a weighted allocation favoring certain services), you may use it. You **must** then include supporting documentation for that alternate allocation basis used.

(2) Account Title Descriptions

The costs in each account, or groups of accounts, on Schedule D must be allocated across all programs and services using reasonable, logical cost allocation statistics or bases. Some examples of these allocation bases are:

- Salaries and wages: time studies or actual time spent
- Fringe benefits and payroll taxes: salary and wage allocations
- Professional and contract services: direct allocation or time spent
- Supplies, telephone, postage, etc.: direct charges or usage (supply allocation may be made based on requisitions from a central storeroom, etc.)
- Transportation: mileage or travel time spent
- Occupancy, repairs and maintenance, insurance, and depreciation: square footage
- All other direct expense: directly relate to a service or program to extent possible
- Indirect expenses: accumulation of all other costs per service or program

The account numbers for expenditures are not intended to be all-inclusive in detailing expenses of a provider. The numbering system used on this schedule is not important, other than to have a basis of identifying object expenses in a manner that is uniform for reporting purposes.

Additional instructions for reporting selected line items follow.

Line 2120: Professional Direct Staff. These positions provide assistance and support to direct support staff, may provide some direct service to the member in the absence of direct support staff, and may supervise some direct support staff activities. Examples of positions include program directors, program supervisors, team leaders, and coordinators.

Calculate the salary expense related to this line item by multiplying the position's salary by the percentage of time spent in the specific program. This does not include administrative time. Administrative time is spent on general management of program operations and is not a direct cost.

Line 2130: Other Direct Staff. These positions provide direct support and assistance to the members. The wage amount is cash compensation and non-cash compensation (such as room and board), when applicable.

Direct support wages must reflect all direct support hours provided by agency personnel, including time spent on progress notes, phone calls, and staffing meetings. Travel time to and from the service site should be accumulated separately from direct service time. Documentation should be available to support the travel time.

This item also includes contract services that provide direct support and assistance to members. The position is instead of, or in addition to, a direct support employee. Contract payments are made to persons who are not employees of the agency.

The total number of direct support and contracted hours corresponding to the direct wages must equal the direct support hours listed in the service plan.

Line 2290: Other Benefits. This item includes other benefits provided for employees, excluding travel and training costs.

Line 3210: Mileage and Auto Rental. This item includes staff mileage and expense. Mileage to and from the service site may be included as an indirect expense. Mileage cost reported is limited to the DHS employee reimbursement rate.

Line 3250: Agency Vehicles Expense. Include expense for the operation and maintenance of agency-owned vehicles used for habilitation services. Employee mileage to and from the service site in an agency vehicle may be included as a direct cost. Mileage cost reported is limited to the DHS employee reimbursement rate.

Line 3290: Other Related Transportation. Include expense attributable to the actual transporting of the member (provided by staff, taxi, car pool, and bus fare) to allow the member to have access to community resources and opportunities.

When medical transportation is reimbursed by Medicaid as set forth in 441 Iowa Administrative Code 78.13(249A), those costs must **not** be included as a direct or indirect allowable cost.

Line 3310: Staff Development and Training. Include all registration, tuition costs, travel, and living expenses incurred by the agency in sending staff members or volunteers to regional and national conferences or to workshops or institutes.

Also show the travel and other costs incurred by an agency in bringing in an outside consultant to conduct a training institute in the agency for conferences or institutes in this item.

Line 3520: Other. Include consultation expenses (such as an interpreter) and expenses directly related to the implementation of instructional activities identified in the member's habilitation service plan.

(3) Unit of Service

For home-based habilitation, a daily rate may be established when a member receives direct supervision for 14 or more hours per day averaged over a calendar month.

For day habilitation and prevocational habilitation, a half-day is 1 to 4 hours and a full day is 4 to 8 hours.

For supported employment, a unit of service is hourly except for job development and employer development, which are paid per job placement.

Units of service must be entered for **all** clients served.

You must maintain the detailed records for each location or site (each provider number) in a format that can be easily reviewed or audited at any time. A discussion of "parent" cost reports is presented in Parent Cost Report below.

h. Schedule D-1

The purpose of Schedule D-1, "Calculation of Home-Based Consumer Cost Limits," is to calculate the cost per home-based habilitation consumer for consumer needs items and to determine the reasonableness of these items.

A member is eligible for $1,570 of consumer items on an annual basis. The 12-month total of Schedule D lines 3290, Other Related Transportation; 3520, Consulting, and 4320, Other Instruction, cannot exceed $1,570 per consumer.

These costs need to be accumulated on an annual basis, with adjustments made for any excesses over the limit, and must be included in the member's case plan.

These expenses are defined as specific costs associated to the member. First seek all payment of these expenses from the member; second, from community resources; and third, from habilitation services program.

The agency is responsible for tracking member costs individually to ensure the cost remains within the limit. Maintain documentation to track the costs per member adequately.

Complete a column for each home-based member. Report the member's item costs from agency accounting records. Compare the amount per member against the limit of $1,570. Cost in excess of the variance must be adjusted from Schedule D in Column 3 – Other Non-Reimbursable Expenses.

i. Schedule E

The purpose of Schedule E, Comparative Balance Sheet, is to report the balance sheet of the provider as of the end of the reporting period. You must either complete this schedule or include a copy of your current or most recent independent audit report.

Under "Assets, Liabilities, and Equity," the total assets must equal the total liabilities and equity.

Balance at End of Current Period: Enter the amount in effect for the last day of the reporting period.

Balance at End of Prior Period: Enter the amount in effect for the last day of the previous reporting period.

Under "Reconciliation of Equity or Fund Balance," the "add" and "deduct" entries should provide an explanation of any difference in the total equity of fund balance between the beginning and end of period.

Total Equity or Fund Balance Beginning of Period: This amount should be the same as the total liabilities and equity for the "balance at end of prior period." Add revenues from Schedule A and deduct expenses from Schedule D.

Total Equity or Fund Balance End of Period: This amount should be the same as the total liabilities and equity for the "balance at end of current period."

j. Schedule F

The purpose of Schedule F, Cost Allocation Procedures, is to report other supplemental information related to agency operations and accounting procedures. Complete Schedule F when your agency provides more than one service or service component. Schedule F is very important and must be completed in its entirety.

Cost allocations are required for direct costs benefiting more than one service or service component and for the provider's indirect costs.

"Direct" costs are costs that are directly identifiable to services or components. "Indirect" costs, although they may benefit all services, generally are not readily identifiable with each service or service component. (See Schedule D for examples.)

The schedule provides questions about methods used in allocating expenses that benefit more than one service or service component. You should be able to support the basis used in allocating these costs. You may be required to obtain prior approval of the cost allocation plan from the IME Provider Cost Audit and Rate Setting Unit.

Commonly accepted cost allocation bases are discussed in the instructions for indirect costs on Schedule D. If your agency is using other methods to allocate costs to all services and programs (i.e., the percentage of clients served within each program or service), you must be sure to specify the method and supply supporting justification.

Supporting schedules or working papers **must** be included to fully disclose how costs are being allocated between the different programs and services (i.e., time studies, square footage).

You must also specify the methodology being used to determine the amount of indirect costs attributable to each program or service. Merely responding to the questions on this schedule with a "yes" or "no" answer will not be considered sufficient. Failure to fully disclose cost apportionment methods may serve to delay implementation of a new rate or completion of a final year-end cost settlement.

k. Parent Cost Report

Agencies that provide habilitation services at more than one location are allowed to obtain additional provider numbers and submit a cost report for each separate provider number if there is substantial difference in costs between locations. Providers are encouraged to use only one provider number when possible.

Agencies that are offering habilitation services using more than one Medicaid provider number must prepare a "parent" cost report by consolidating all costs and unit statistics from the cost reports of each separate provider number within their agency.

In order to tie all such cost reports together, the agency must reflect its federal tax identification number on the parent cost report and on all cost reports for its individual provider numbers.

The agency must then consolidate the costs and units for all services separately and report the respective totals in the parent cost report for IME review purposes. The parent cost report will not by itself form the basis for cost settlements and rate determinations, but will be used to review the entire operations of the provider at one time.

The parent cost report is significantly the same as the standard cost report used for each individual provider number. To complete the parent cost report, consolidate all costs and units for your individual locations and services by type of service. For example, consolidate all costs and units for all "home-based habilitation – hourly" (W1207) services rendered under all your provider numbers.

Also consolidate the costs of all services and programs other than habilitation services at all your locations into the "Other Programs" column of the parent cost report. When completed, the totals of all of the individual cost reports representing each provider number should equal the costs and units reflected in the parent cost report.

F. CMS-1500 CLAIM FORM

Providers of habilitation services shall submit claims using form CMS-1500, *Health Insurance Claim Form*. To view a sample of this form on line, click here.

The table below contains information that will aid in the completion of the claim form. The table follows the form by field number and name, giving a brief description of the information to be entered, and whether providing information in that field is required, optional or conditional of the individual member's situation.

Special Instructions for Habilitation Services Providers:

A diagnosis code is required to be entered in field 21. In the event that a provider may not have documentation of the diagnosis code for a member, contact the member's case manager. The case manager should have the member's diagnosis on file. If the diagnosis code is not available from the case manager, the provider may use code V00.01.

NOTE: Electronic media claim (EMC) submitters should also refer to your EMC specifications for claim completion instructions.

FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
1.	CHECK ONE	**REQUIRED** Check the applicable program block.
1a.	INSURED'S ID NUMBER	**REQUIRED** Enter the Medicaid member's Medicaid number, found on the *Medical Assistance Eligibility Card*. The Medicaid "member" is defined as a recipient of services who has Iowa Medicaid coverage. The Medicaid number consists of seven digits followed by a letter, e.g., 1234567A. Verify eligibility by visiting the web portal or by calling the Eligibility Verification System (ELVS) at 800-338-7752 or 515-323-9639, local in the Des Moines area. To establish a web portal account, call 800-967-7902.
2.	PATIENT'S NAME	**REQUIRED** Enter the last name, first name, and middle initial of the Medicaid member.
3.	PATIENT'S BIRTHDATE	**OPTIONAL** Enter the Medicaid member's birth month, day, year, and sex. Completing this field may expedite processing of your claim.

FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
4.	INSURED'S NAME	**OPTIONAL** For Iowa Medicaid purposes, the member receiving services is always the "insured." If the member is covered through other insurance, the policyholder is the "other insured."
5.	PATIENT'S ADDRESS	**OPTIONAL** Enter the address and phone number of the member, if available.
6.	PATIENT RELATIONSHIP TO INSURED	**OPTIONAL** For Medicaid purposes, the "insured" is always the same as the patient.
7.	INSURED'S ADDRESS	**OPTIONAL** For Medicaid purposes, the "insured" is always the same as the patient.
8.	PATIENT STATUS	**REQUIRED, IF KNOWN** Check boxes corresponding to the patient's current marital and occupational status.
9a-d.	OTHER INSURED'S NAME, ETC.	**SITUATIONAL** Required if the Medicaid member is covered under other additional insurance. Enter the name of the policyholder of that insurance, as well as the policy or group number, the employer or school name under which coverage is offered, and the name of the plan or program. If 11d is "yes," these boxes must be completed.
10.	IS PATIENT'S CONDITION RELATED TO	**REQUIRED, IF KNOWN** Check the applicable box to indicate whether or not treatment billed on this claim is for a condition that is somehow work-related or accident-related. If the patient's condition is related to employment or an accident, and other insurance has denied payment, complete 11d, marking the "yes" and "no" boxes.
10d.	RESERVED FOR LOCAL USE	**OPTIONAL** No entry required.
11a-c.	INSURED'S POLICY GROUP OR FECA NUMBER AND OTHER INFORMATION	**OPTIONAL** For Medicaid purposes, the "insured" is always the same as the patient.

FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
11d.	IS THERE ANOTHER HEALTH BENEFIT PLAN?	**REQUIRED** If the Medicaid member has other insurance, check "yes" and enter payment amount in field 29. If "yes," then boxes 9a-9d must be completed. If there is no other insurance, check "no." If you have received a denial of payment from another insurance, check **both** "yes" and "no" to indicate that there is other insurance, but that the benefits were denied. Proof of denials must be included in the patient record. Request this information from the member. You may also determine if other insurance exists by visiting the web portal or by calling the Eligibility Verification System (ELVS) at 800-338-7752 or 515-323-9639, local in the Des Moines area. To establish a web portal account, call 800-967-7902. NOTE: Auditing will be performed on a random basis to ensure correct billing.
12.	PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	**OPTIONAL** No entry required.
13.	INSURED OR AUTHORIZED PERSON'S SIGNATURE	**OPTIONAL** No entry required.
14.	DATE OF CURRENT ILLNESS, INJURY OR PREGNANCY	**SITUATIONAL** Enter the date of the onset of treatment, using mm/dd/yy format. For pregnancy, use the date of the last menstrual period. No entry is required for preventative care.
15.	IF THE PATIENT HAS HAD SAME OR SIMILAR ILLNESS...	**SITUATIONAL** Chiropractors must enter the date of the current X-ray, using mm/dd/yy format. For all others, no entry is required.
16.	DATES PATIENT UNABLE TO WORK...	**OPTIONAL** No entry required.
17.	NAME OF REFERRING PROVIDER OR OTHER SOURCE	**SITUATIONAL** Required if the referring provider is not enrolled as an Iowa Medicaid provider. "Referring provider" is defined as the healthcare provider that directed the patient to your office.

FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
17a.		**LEAVE BLANK** The claim will be returned if any information is entered in this field.
17b.	NPI	**REQUIRED** in the following situations: ♦ If the patient is a MediPASS member and the MediPASS provider authorized the service, enter the 10-digit NPI of the referring provider. ♦ If the claim is for consultation, independent laboratory services, or medical equipment, enter the NPI of the referring or prescribing provider. ♦ If the patient is on lock-in and the designated lock-in provider authorized the service, enter the NPI of the lock-in provider.
18.	HOSPITALIZATION DATES RELATED TO...	**OPTIONAL** No entry required.
19.	RESERVED FOR LOCAL USE	**OPTIONAL** No entry required. Pregnancy is indicated with a pregnancy diagnosis code in box 21. If you are unable to enter a pregnancy diagnosis code in any of the fields in box 21, write in this box, "Y – Pregnant."
20.	OUTSIDE LAB	**OPTIONAL** No entry required.
21.	DIAGNOSIS OR NATURE OF ILLNESS	**REQUIRED** Indicate the applicable ICD-9-CM diagnosis codes in order of importance to a maximum of four diagnoses (1-primary, 2-secondary, 3-tertiary, and 4-quaternary). If the patient is pregnant, one of the diagnosis codes must indicate pregnancy. The pregnancy diagnosis codes are as follows: 640 through 648 670 through 677 V22 V23
22.	MEDICAID RESUBMISSION CODE...	This field will be required at a future date. Instructions will be provided before the requirement is implemented.
23.	PRIOR AUTHORIZATION NUMBER	**SITUATIONAL** If there is a prior authorization, enter the prior authorization number. Obtain this number from the prior authorization form.

FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
24. A Top Shaded Portion	DATE(S) OF SERVICE/NDC	**REQUIRED** for provider-administered drugs. Enter qualifier "N$" followed by the National Drug Code for the drug referenced in box 24d, HCPCs. Do not use spaces or symbols in entering this information.
24. A Lower Portion	DATE(S) OF SERVICE/NDC	**REQUIRED** Enter the month, day, and year under both the "From" and "To" categories for each procedure, service, or supply. If the "From-To" dates span more than one calendar month, enter each month on a separate line. Because eligibility is approved on a month-by-month basis, spanning or overlapping billing months could cause the entire claim to be denied.
24. B	PLACE OF SERVICE	**REQUIRED** Using the chart below, enter the number corresponding to the place service was provided. Do not use alphabetic characters. 11 Office 12 Home 21 Inpatient hospital 22 Outpatient hospital 23 Emergency room – hospital 24 Ambulatory surgical center 25 Birthing center 26 Military treatment facility 31 Skilled nursing 32 Nursing facility 33 Custodial care facility 34 Hospice 41 Ambulance – land 42 Ambulance – air or water 51 Inpatient psychiatric facility 52 Psychiatric facility – partial hospitalization 53 Community mental health center 54 Intermediate care facility/mentally retarded 55 Residential substance abuse treatment facility 56 Psychiatric residential treatment center 61 Comprehensive inpatient rehabilitation facility 62 Comprehensive outpatient rehabilitation facility 65 End-stage renal disease treatment 71 State or local public health clinic 81 Independent laboratory 99 Other unlisted facility

FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
24. C	EMG	**OPTIONAL** No entry required.
24. D	PROCEDURES, SERVICES OR SUPPLIES	**REQUIRED** Enter the codes for each of the dates of service. **Do not** list services for which no fees were charged or enter the description. Enter the procedures, services or supplies using the CMS Healthcare Common Procedure Coding System (HCPCS) code or valid Current Procedural Terminology (CPT) codes. When applicable, show HCPCs code modifiers with the HCPCs code.
24. E	DIAGNOSIS POINTER	**REQUIRED** Indicate the corresponding diagnosis code from field 21 by entering the number of its position, e.g., 3. **Do not** write the actual diagnosis code in this field. Doing so will cause the claim to deny. There is a maximum of four diagnosis codes per claim.
24. F	$ CHARGES	**REQUIRED** Enter the usual and customary charge for each line item. This is defined as the provider's customary charges to the public for the services.
24. G	DAYS OR UNITS	**REQUIRED** Enter the number of times this procedure was performed or the number of supply items dispensed. If the procedure code specifies the number of units, enter "1." When billing general anesthesia, this entry must reflect the total **minutes** of anesthesia.
24. H	EPSDT/FAMILY PLANNING	**SITUATIONAL** Required if services are a result of an EPSDT (Care for Kids) screen (enter "E") or are family planning services (enter "F")..
24. I	ID QUAL.	**LEAVE BLANK** The claim will be returned if any information is entered in this field.
24. J	RENDERING PROVIDER ID #	**LEAVE BLANK** The claim will be returned if any information is entered in this field.
25.	FEDERAL TAX ID NUMBER	**OPTIONAL** No entry required.

FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
26.	PATIENT'S ACCOUNT NUMBER	**FOR PROVIDER USE** Enter the account number you have assigned to the patient. This field is limited to 10 alphabetical or numeric characters.
27.	ACCEPT ASSIGNMENT	**OPTIONAL** No entry required.
28.	TOTAL CLAIM CHARGE	**REQUIRED** Enter the total of the line item charges. If more than one claim form is used to bill services performed, total each claim form separately. Do not carry over any charges to another claim form.
29.	AMOUNT PAID	**SITUATIONAL** Required if the member has other insurance and that insurance made a payment on this claim. Do not submit this claim until you receive a payment or denial from the other carrier. Proof of denial must be kept in the patient record. Enter only the amount paid by other insurance. Do not list member copayments, Medicare payments, or previous Medicaid payments on this claim.
30.	BALANCE DUE	**REQUIRED** Enter the amount of total charges less the amount entered in field 29.
31.	SIGNATURE OF PHYSICIAN OR SUPPLIER	**REQUIRED** Enter the signature of either the provider or the provider's authorized representative and the original filing date. The signatory must be someone who can legally attest to the service provided and can bind the organization to the declarations on the back of this form. If the signature is computer-generated block letters, the signature must be initialed. A signature stamp may be used.
32.	SERVICE FACILITY LOCATION INFORMATION	**OPTIONAL** Enter the name and address associated with the rendering provider. NOTE: The ZIP code must match the zip code confirmed during NPI verification or during enrollment. To view the ZIP code provided, return to imeservices.org.
32a.	NPI	**OPTIONAL** Enter the NPI of the facility where services were rendered.

FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
32b.		**LEAVE BLANK** The claim will be returned if any information is entered in this field.
33.	BILLING PROVIDER INFO AND PHONE #	**REQUIRED** Enter the complete name and address of the billing provider, the provider that is requesting to be paid for the services rendered. NOTE: The address must contain the ZIP code associated with the billing provider's NPI. To view the ZIP code provided, visit imeservices.org.
33a.	NPI	**REQUIRED** Enter the ten-digit NPI of the billing provider.
33b.		**REQUIRED** Enter "ZZ" followed by the taxonomy code associated with the billing provider's NPI. Do not enter spaces or symbols. The taxonomy code must match the taxonomy code confirmed during NPI verification. To view the confirmed taxonomy code, visit imeservices.org.

Providers interested in billing electronically can contact EDISS (Electronic Data Interchange Support Services) at 800-967-7902 or by e-mail at edi@noridian.com.

G. REMITTANCE ADVICE

To simplify your accounts receivable reconciliation and posting functions, you will receive a comprehensive *Remittance Advice* with each Medicaid payment. The *Remittance Advice* is also available on magnetic computer tape for automated account receivable posting. To view a sample of this form on line, click here.

1. Remittance Advice Explanation

The *Remittance Advice* is separated into categories indicating the status of those claims listed below. Categories of the *Remittance Advice* include paid, denied, and suspended claims.

- **Paid** indicates all processed claims, credits and adjustments for which there is full or partial reimbursement.
- **Denied** represents all processed claims for which no reimbursement is made.
- **Suspended** reflects claims which are currently in process pending resolution of one or more issues (member eligibility determination, reduction of charges, third party benefit determination, etc.).

Suspended claims may or may not print depending on which option was specified on the Medicaid Provider Application at the time of enrollment. You chose one of the following:

- Print suspended claims only once.
- Print all suspended claims until paid or denied.
- Do not print suspended claims.

Note that claim credits or recoupments (reversed) appear as regular claims with the exception that the transaction control number contains a “1” in the twelfth position and reimbursement appears as a negative amount.

An adjustment to a previously paid claim produces two transactions on the *Remittance Advice*. The first appears as a credit to negate the claim; the second is the replacement or adjusted claim, containing a “2” in the twelfth position of the transaction control number.

If the total of the credit amounts exceeds that of reimbursement made, the resulting difference (amount of credit – the amount of reimbursement) is carried forward and no check is issued. Subsequent reimbursement will be applied to the credit balance, as well, until the credit balance is exhausted.

An example of the *Remittance Advice* and a detailed field-by-field description of each informational line follows. It is important to study these examples to gain a thorough understanding of each element as each *Remittance Advice* contains important information about claims and expected reimbursement.

Regardless of one's understanding of the *Remittance Advice*, it is sometimes necessary to contact the IME Provider Services Unit with questions. When doing so, keep the *Remittance Advice* handy and refer to the transaction control number of the particular claim. This will result in timely, accurate information about the claim in question.

2. Remittance Advice Field Descriptions

NUMBER	DESCRIPTION
1.	Billing provider's name as specified on the *Medicaid Provider Enrollment Application*.
2.	*Remittance Advice* number.
3.	Date claim paid.
4.	Billing provider's Medicaid (Title XIX) number.
5.	*Remittance Advice* page number.
6.	Type of claim used to bill Medicaid.
7.	Status of following claims: • Paid. Claims for which reimbursement is being made. • Denied. Claims for which no reimbursement is being made. • Suspended. Claims in process. These claims have not yet been paid or denied.
8.	Member's last and first name.

NUMBER	DESCRIPTION
9.	Member's Medicaid (Title XIX) number.
10.	Transaction control number assigned to each claim by the IME. Please use this number when making claim inquiries.
11.	Total charges submitted by provider.
12.	Total amount applied to this claim from other resources, i.e., other insurance or spenddown.
13.	Total amount of Medicaid reimbursement as allowed for this claim.
14.	Total amount of member copayment deducted from this claim.
15.	Medical record number as assigned by provider; 10 characters are printable.
16.	Explanation of benefits code for informational purposes or to explain why a claim denied. Refer to the end of the *Remittance Advice* for explanation of the EOB code.
17.	Line item number.
18.	The first date of service for the billed procedure.
19.	The procedure code for the rendered service.
20.	The number of units of rendered service.
21.	Charge submitted by provider for line item.
22.	Amount applied to this line item from other resources, i.e., other insurance, spenddown.
23.	Amount of Medicaid reimbursement as allowed for this line item.
24.	Amount of member copayment deducted for this line item.
25.	Treating provider's Medicaid (Title XIX) number.

NUMBER	DESCRIPTION
26.	Allowed charge source code: **B** Billed charge **F** Fee schedule **M** Manually priced **N** Provider charge rate **P** Group therapy **Q** EPSDT total screen over 17 years **R** EPSDT total under 18 years **S** EPSDT partial over 17 years **T** EPSDT partial under 18 years **U** Gynecology fee **V** Obstetrics fee **W** Child fee
27.	Remittance totals (found at the end of the *Remittance Advice*): • Number of paid original claims, the amount billed by the provider, and the amount allowed and reimbursed by Medicaid. • Number of paid adjusted claims, amount billed by provider, and amount allowed and reimbursed by Medicaid. • Number of denied original claims and amount billed by provider. • Number of denied adjusted claims and amount billed by provider. • Number of pended claims (in process) and amount billed by provider. • Amount of check.
28.	Description of individual explanation of benefits codes. The EOB code leads, followed by important information and advice.

Medicaid Enterprise
Department of Human Services

For Human Services use only:

General Letter No. 8-AP-273
Employees' Manual, Title 8
Medicaid Appendix

June 15, 2007

HCBS HABILITATION SERVICES MANUAL TRANSMITTAL NO. 07-1

ISSUED BY: Division of Medical Services, Iowa Department of Human Services

SUBJECT: ***HCBS Habilitation Services Manual***, Title Page, new; Table of Contents, new;

Chapter I, ***General Program Policies***, Title Page, Table of Contents, pages 1 through 59, and forms 470-4166, 470-3744, and 470-0040;

Chapter II, ***Member Eligibility***, Title Page, Table of Contents (pages 1 and 2), pages 1 through 33, and forms 470-2213, 470-1911, 470-2188, 470-3348, 470-2580, 470-2927, 470-2927(S), 470-3931, 470-4299, 470-2579, 470-2582, 470-2629, 470-3864, and 470-3865;

Chapter III, ***Provider-Specific Policies***, Title Page, new; Table of Contents (pages 1 and 2), new; pages 1 through 61, new; and the following new forms:

470-4425	*Financial and Statistical Report for Habilitation Services*
CMS-1500	*Health Insurance Claim Form*
	Remittance Advice

Appendix, Title Page, Table of Contents, and pages 1 through 18

Summary

This letter transmits a new manual for providers of HCBS Habilitation Services. This new service category is intended to replace rehabilitative services for adults with chronic mental illness.

The manual is comprised of four sections:

- Chapter I contains information about Iowa Medicaid administration, coverage, and reimbursement that applies to all types of providers.
- Chapter II describes the different ways of attaining and demonstrating Medicaid eligibility. It also applies to all provider types.
- Chapter III explains Medicaid requirements specific to habilitation services. The chapter includes information regarding:
  - Provider eligibility for enrollment;
  - Member eligibility to receive services;
  - What services are covered and what requirements apply to them;
  - Provider documentation of services;
  - The cost reporting and cost settlement processes; and
  - The forms and instructions used for billing for remedial services.
- The Appendix contains directories of local Department of Human Services offices, Social Security offices in Iowa, and EPSDT care and coordination agencies.

Date Effective

January 1, 2007

Material Superseded

None

Additional Information

The new provider manual can be found at:

www.ime.state.ia.us/providers

If you do not have Internet access, you may request a paper copy of this manual transmittal by sending a written request to:

Iowa Medicaid Enterprise
Provider Services
PO Box 36450
Des Moines, IA 50315

Include your Medicaid provider number, name, address, provider type, and the transmittal number that you are requesting.

If any portion of this manual is not clear, please direct your inquiries to the Iowa Medicaid Enterprise Provider Services Unit.

Medicaid Enterprise
Department of Human Services

For Human Services use only:

General Letter No. 8-AP-287
Employees' Manual, Title 8
Medicaid Appendix

July 18, 2008

HCBS HABILITATION SERVICES MANUAL TRANSMITTAL NO. 08-1

ISSUED BY: Division of Medical Services, Iowa Department of Human Services

SUBJECT: ***HCBS Habilitation Services Manual***, Chapter III, *Provider-Specific* Policies, Table of Contents (page 1), revised; pages 6, 7, 9, 11 through 15, 22, 23 through 28, 30, 32, 34, 40, 41, 42, 46, 47, 49, and 52 through 58, revised; pages 22a and 22b, new; and the following forms:

SES/RA-1 *Supported Employment Readiness Analysis*, new.
470-4425 *Financial and Statistical Report for Habilitation Services*, revised

Summary

This letter transmits a revision for providers of HCBS habilitation services that includes:

- Updated ISIS instructions due to system changes.
- Description of new components of supported employment: activities to obtain a job and corresponding changes to procedure codes and cost reporting instructions. The new components include:
  - **Job development** services directed toward obtaining competitive employment.
  - **Employer development** services focused on supporting employers in hiring and retaining members in their workforce and communicating expectations of the business with the interdisciplinary team.
  - **Enhanced job search** activities associated with obtaining initial employment after job development services have been provided for a minimum of 30 days, or with assisting a member in changing jobs due to lay-off, termination, or personal choice.
- Updated cost report and instructions. The revised cost report, form 470-4425, *Financial and Statistical Report for Habilitation Services,* is available at: **http://www.ime.state.ia.us/docs/HabilitationWaiverCostReport.xls**
- New information on member enrollment for habilitation services while enrolled for a HCBS waiver program.
- Updated instructions for completion of CMS-1500, *Health Insurance Claim Form*.
- Clarifying language to correct inconsistent wording.

Date Effective

June 1, 2008

Material Superseded

Remove the following pages from Chapter III of the ***Habilitation Services Manual***, and destroy them:

Page	Date
Table of Contents (page 1)	January 1, 2007
6, 7, 9, 11-15, 22-28, 30, 32, 34	January 1, 2007
470-4425	12/06
40-42, 46, 47, 49, and 52-58	January 1, 2007

Additional Information

The new provider manual can be found at:

www.ime.state.ia.us/providers

If you do not have Internet access, you may request a paper copy of this manual transmittal by sending a written request to:

Iowa Medicaid Enterprise, Provider Services Unit
PO Box 36450
Des Moines, IA 50315

Include your Medicaid provider number, name, address, provider type, and the transmittal number that you are requesting.

If any portion of this manual is not clear, please direct your inquiries to the Iowa Medicaid Enterprise Provider Services Unit.